Enfield Multi-Agency Practice Week - Physical abuse
WORKSHOP: What have we learned from Star and Arthur

Presented by Dr Andres Freiberg and Chantel Palmer

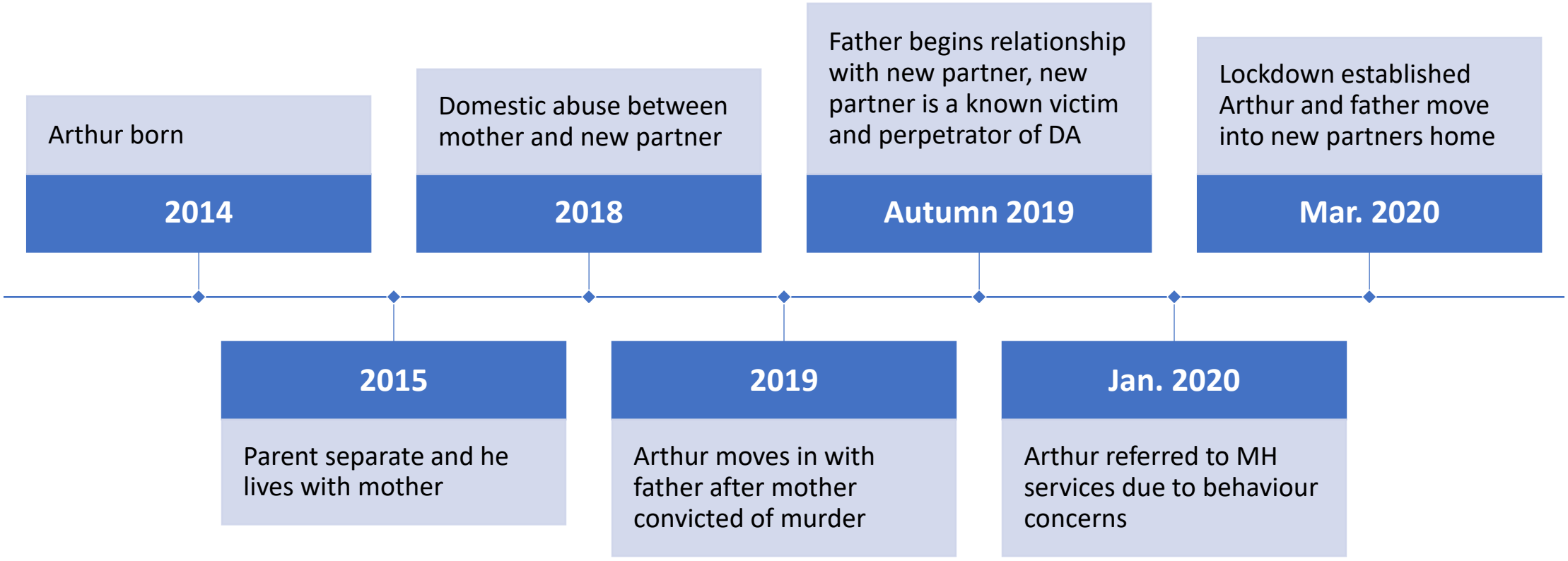
Background

- Arthur Labinjo-Hughes died in Solihull aged six on 17th June 2020. His father's partner, Emma Tustin, was convicted on 1st December 2021 of his murder. Arthur's father, Thomas Hughes, was convicted of manslaughter. They are now both serving prison terms.

- Star Hobson died in Bradford aged 16 months on 22nd September 2020. Her mother's partner, Savannah Brockhill, was subsequently convicted of murder on 15th December 2021 and her mother, Frankie Smith, was convicted of causing or allowing her death. They too are now in prison.

- Both children died during the Covid-19 pandemic

Key Dates – Arthur



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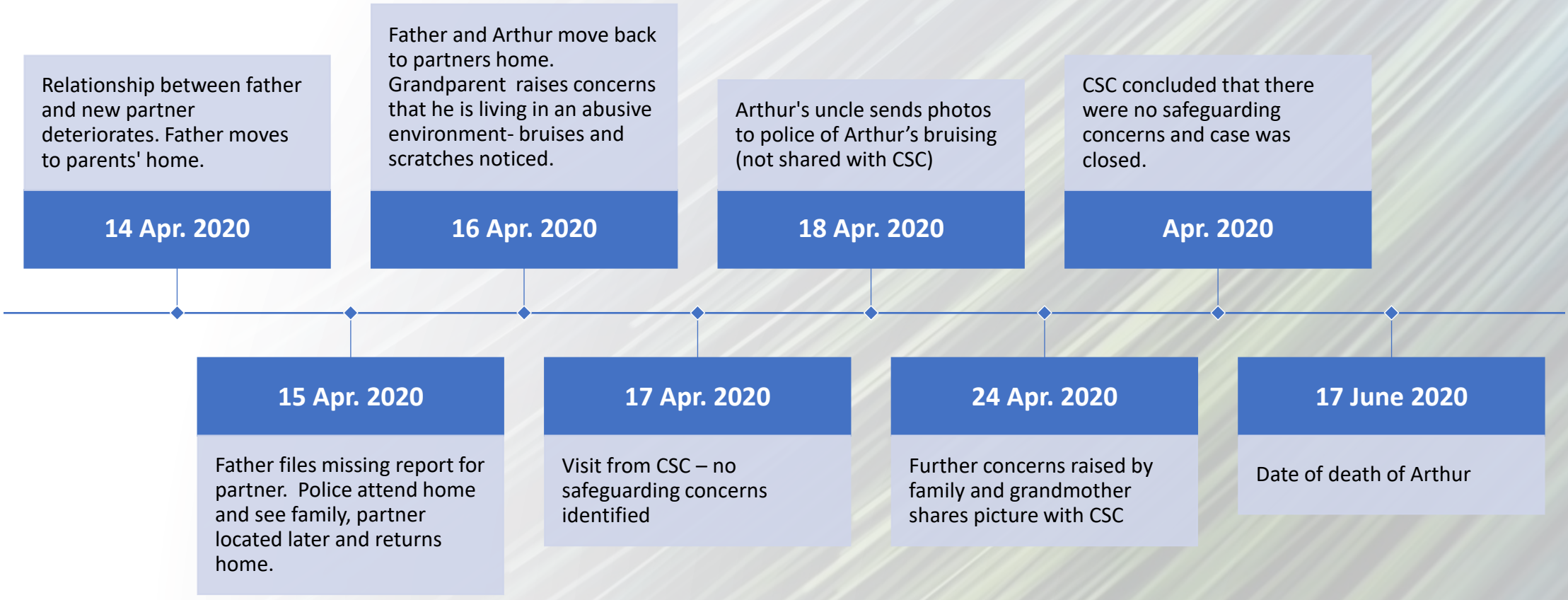

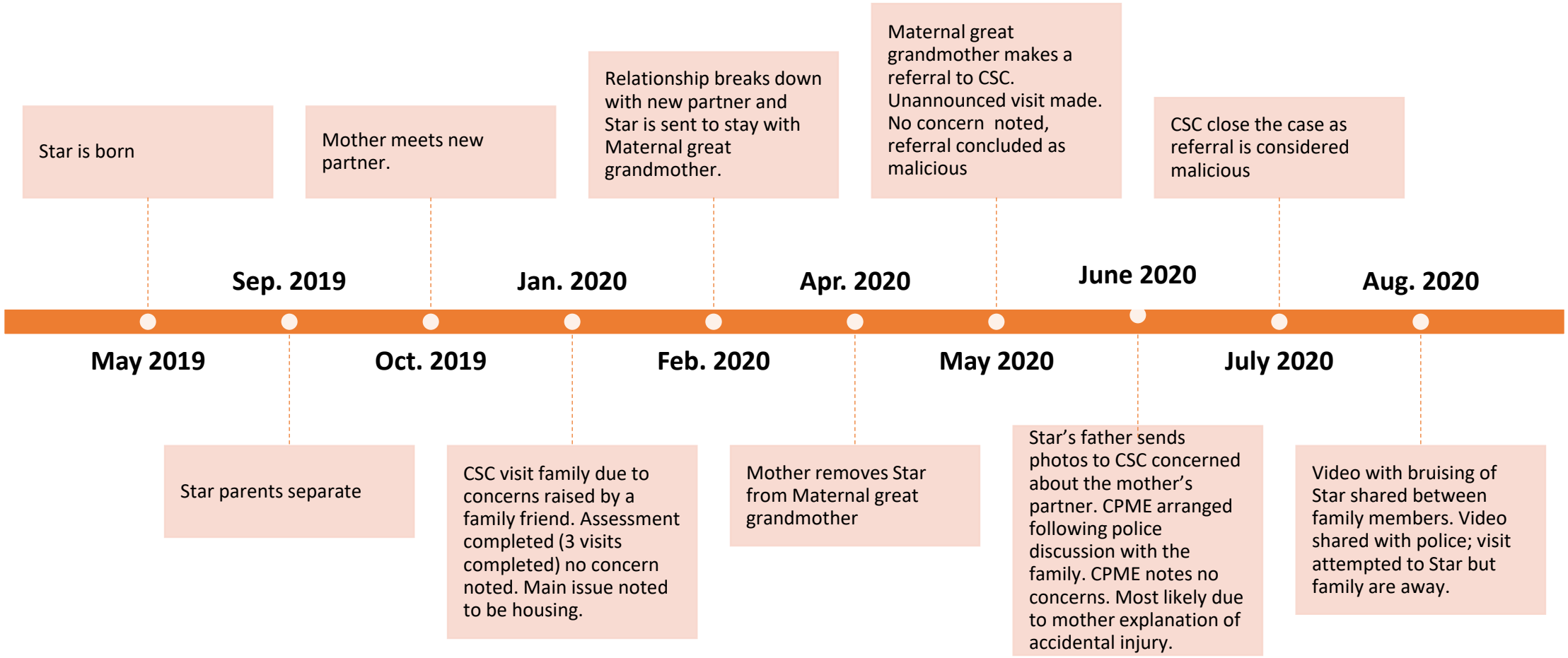

Key Dates - Star

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Maternal grandfather contacted CSC about bruising video of Star. SW contacts mother who explains it was accidental and this was shared with previous SW.

Star visited by CSC no further action

Star's date of death.

2 Sep. 2020 | 3 Sep. | 4 Sep. | 15 Sep. | 22 Sep.

GP contacts family to advise that Star should attend GP. This is not complied with

Case closed to CSC on the basis concerns are unsubstantiated and malicious

Key Practice Issues

- Lack of timely and appropriate information sharing
- Evidence was not pieced together and considered in the round
- Understanding what the child's daily life is like, where this might not be straightforward
- Listening to the views of the wider family and those who know the child well
- Appropriate response to domestic abuse
- Working with diverse communities
- Working with families whose engagement is reluctant and sporadic
- Critical thinking and challenge
- Leadership and culture

What went wrong?

- Weaknesses in information sharing and seeking within and between agencies.
- A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.
- A need for sharper specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse.
- Underpinning these issues, is the need for leaders to have a powerful enabling impact on child protection practice, creating and protecting the optimum organisational conditions for undertaking this complex work.

How can we improve our practice and knowledge?

- Understanding what the child's daily life is like, where this might not be straightforward
- Listening to the views of the wider family and those who know the child well
- Specialist skills and expertise for working with families whose engagement is reluctant or sporadic
- Working with diverse communities
- Appropriate responses to domestic abuse
- Specialist skills and expertise for undertaking child protection investigations

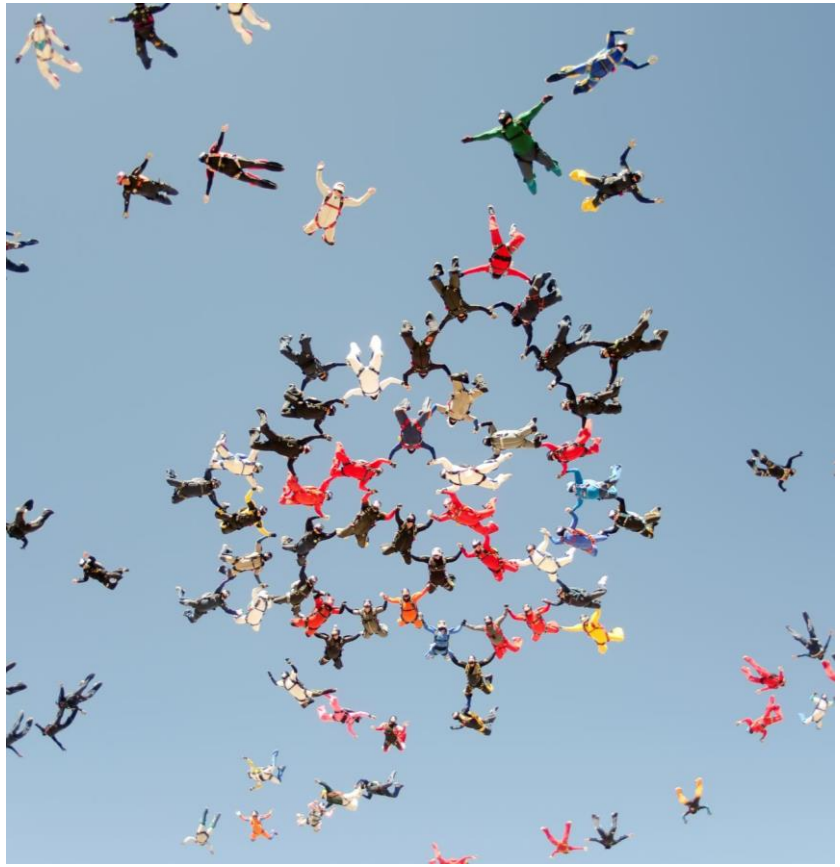
Changes to systems and processes

- Appropriate information sharing and seeking
- Critical thinking and challenge within and between agencies
- Leadership and culture
- Wider service context

Key messages for all Safeguarding Partners:

All Safeguarding Partners should assure themselves that:

- Robust multi-agency strategy discussions are always being held whenever it is suspected a child may be at risk of suffering significant harm.
- Sufficient resources are in place from across all agencies to allow for the necessary multi-agency engagement in child protection processes e.g., strategy discussions, section 47 enquiries, Initial Child Protection Conferences.
- There are robust information sharing arrangements and protocols in place across the Partnership.
- Referrals are not deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager. Indeed, the Panel believes that the use of such language has many attendant risks and would therefore discourage its usage as a professional conclusion.



National Recommendations

Recommendation 1: A new expert-led, multi-agency model for child protection investigation, planning, intervention, and review.

Recommendation 2: Establishing National Multi-Agency Practice Standards for Child Protection.

Recommendation 3: Strengthening the local Safeguarding Partners to ensure proper co-ordination and involvement of all agencies.

Recommendation 4: Changes to multi-agency inspection to better understand local performance and drive improvement.

National Recommendations

Recommendation 5: A new role for the Child Safeguarding Practice Review Panel in driving practice improvement in Safeguarding Partners.

Recommendation 6: A sharper performance focus and better co-ordination of child protection policy in central Government.

Recommendation 7: Using the potential of data to help professionals protect children.

Recommendation 8: Specific practice improvements in relation to domestic abuse.

Enfield response

PHYSICAL ABUSE AUDIT

TRAINING & AWARENESS

POLICY REVIEW

PRACTICE WEEK

What can we do now?

Be child-centred and outcome-focused. Continuously ask:

"What is this child's life like, everyday / What is their lived experience?"

"What difference is this making in the life of the child?"

- Listen to the views of the wider family and those who know the child well
- Re-consider language – "Malicious referrals"
- Share information proactively
- Robust multi-agency strategy discussions should always be held whenever it is suspected a child may be at risk of suffering significant harm.

Resources and Links

NSPCC Summary of the National Review Report - The national review into the murders of Arthur Labinjo-Hughes and Star Hobson: CASPAR briefing | NSPCC Learning)

Relevant local Enfield Safeguarding Children Partnership Policies and Procedures:

london_multi-agency_safeguarding_data_sharing_agreement.pdf (enfield.gov.uk)

Escalation-protocol-updated-2024.pdf (enfield.gov.uk)

ECSL3102-Threshold-Guidance-2023.pdf (enfield.gov.uk)